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The From Survivor to Thriver program: RCT of an online therapist-facilitated program for rape-related PTSD☆,☆☆,★

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ABSTRACT

This study evaluated the efficacy of the From Survivor to Thriver program, an interactive, online therapist-facilitated cognitive-behavioral program for rape-related PTSD. Eighty-seven college women with rape-related PTSD were randomized to complete the interactive program ($n = 46$) or a psycho-educational self-help website ($n = 41$). Both programs led to large reductions in interview-assessed PTSD at post-treatment (interactive $d = 2.22$, psycho-educational $d = 1.10$), which were maintained at three month follow-up. Both also led to medium- to large-sized reductions in self-reported depressive and general anxiety symptoms. Follow-up analyses supported that the therapist-facilitated interactive program led to superior outcomes among those with higher pre-treatment PTSD whereas the psycho-educational self-help website led to superior outcomes for individuals with lower pre-treatment PTSD. Future research should examine the efficacy and effectiveness of online interventions for rape-related PTSD including whether treatment intensity matching could be utilized to maximize outcomes and therapist resource efficiency.

1. Introduction

The experience of rape is associated with high rates of post-traumatic stress disorder (PTSD; Boudreaux, Kilpatrick, Resnick, Best, & Saunders, 1998; Breslau et al., 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Rizvi, Vogt, & Resick, 2009; Van Minnen, Arntz, & Keijsers, 2002; Zinzow et al., 2012). Although efficacious treatments for rape-related PTSD exist, help seeking among rape victims remains very low, with few victims accessing available services and many distressed victims delaying treatment for years (Ahrens, Campbell, Ternier-Thames, Wasco, & Sefl, 2007; Foa, Rothbaum, Riggs, & Murdock, 1991; Walsh, Banyard, Moynihan, Ward, & Cohn, 2010). For many rape victims, it is likely that stigma concerns serve as a key barrier to help-seeking. Indeed, a recent study of college rape victims found that only 3% accessed available campus services for victims and that privacy concerns (70%), shame and embarrassment (50%), and concerns about others finding out (39%) were among the reasons most often cited for not utilizing services (Walsh et al., 2010). Thus, there is a need to develop alternative interventions, such as online programs, in order to disseminate efficacious treatments to affected individuals while allaying potential privacy and stigma concerns.

Several online cognitive-behavioral treatments for PTSD have been developed and evaluated, including prolonged exposure based protocols (Lange et al., 2000, 2003; Litz, Engel, Bryant, & Papa, 2007), self-help cognitive-behavioral protocols (Hirai & Clum, 2005; Klein et al., 2010), a cognitive restructuring self-help based protocol with or without exposure components (Spence et al., 2014), and a protocol designed to increase adaptive trauma-related

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coping (Wang, Wang, & Maercker, 2013). These online programs have varied in their level of therapist involvement, including those that were primarily self-help (e.g., Hirai and Clum, 2005; Spence et al., 2014; Wang et al., 2013), those that involved email and/or telephone based therapist support (e.g., Klein et al., 2010; Knaevelsrud & Maercker, 2007; Lange et al., 2003), as well as one which included limited in-person and telephone therapy sessions (Litz et al., 2007). In general, clinical trials have supported the efficacy of these online cognitive-behavioral programs with them leading to large sized reduction in PTSD symptoms from pre- to post-treatment (d_s = 0.8–1.9), as well as larger reductions in PTSD symptoms as compared to waitlist (d_s = 0.4–1.4). In addition, Litz et al. (2007) found that their online program that included limited in-person and telephone based therapy sessions led to superior post-treatment PTSD symptom outcomes as compared to a psycho-educational website, d = 1.0, among a sample of 24 U.S. Department of Defense employees.

Despite the promising nature of these programs, the extant research regarding them suffers from a number of methodological limitations. First, many trials excluded individuals with elevated depressive symptoms and/or individuals with histories of childhood sexual abuse (Hirai & Clum, 2005; Klein et al., 2010; Lange et al., 2000, 2003). As a result, it is unclear whether findings from those studies would generalize to more distressed individuals (e.g., those with comorbid depression or childhood trauma histories). In addition, several trials included individuals with subclinical PTSD as well as those meeting full diagnostic criteria (Hirai & Clum, 2005; Knaevelsrud & Maercker, 2007; Lange et al., 2000, 2003; Wang et al., 2013), and thus it is not known if comparable results would have been obtained if participants were restricted only to those who met full diagnostic criteria. Additionally, with the exception of Litz et al. (2007), no others compared the efficacy of the online program to an active control condition. Also, many of these programs did not leverage the potential advantages of online interventions, such as integrating multimedia into the program (e.g., videos) or using secure online asynchronous communication within the program (as opposed to using email which is less secure). Finally, none of these programs were tailored to meet the needs of a particular population of trauma victims, such as women who have experienced rape.

The aim of the current study was to evaluate the efficacy of The From Survivor to Thriver program, a therapist-facilitated, online cognitive-behavioral program tailored to meet the needs of rape victims with PTSD. The From Survivor to Thriver program is a nine module, online, therapist-facilitated program that utilizes a variety of cognitive behavioral strategies (e.g., relaxation training, cognitive restructuring) to address issues commonly faced by rape victims (e.g., self-blame for the assault, difficulties with trust and intimacy). It includes written text, video content, and written examples of women modeling skills taught in the program. In addition, the program integrates individually tailored written and video feedback from a program therapist. A pilot study with five college women with rape-related PTSD who completed the program in a lab setting over the course of seven weeks supported that it led to large-sized reductions in PTSD symptoms (d = 2.4), anxiety symptoms (d = 1.1), and vulnerability fears (d = 2.7; Littleton, Buck, Rosman, & Grills-Taquechel, 2012).

For the current study, a randomized clinical trial (RCT) was conducted comparing the efficacy of the From Survivor to Thriver program with a self-help psycho-educational website among a sample of college women who met full diagnostic criteria for rape-related PTSD. College women were chosen as participants as they report high rates of rape and current PTSD, as well as low rates of help seeking (e.g., Walsh et al., 2010; Zinzow et al., 2012). In addition, the vast majority of college students utilize the Internet on a regular basis and report comfort with using it for mental health information and support (e.g., Horgan & Sweeney, 2010; Smith, Rainie, & Zickuhr, 2011). Thus, college women seemed a population that might be particularly likely to utilize an online intervention for rape-related PTSD. Based on prior studies of therapist-facilitated and self-help based interventions for PTSD, it was predicted that both programs would be efficacious in reducing PTSD symptomology. Drawing on the findings from the treatment intensity matching literature (e.g., CATS Consortium, 2010; De Leon, Melnick, & Cleland, 2008; Hammond et al., 2012), it was hypothesized that the therapist-facilitated intervention would demonstrate superior efficacy among participants with higher levels of pre-treatment PTSD but not among individuals with lower levels of pre-treatment PTSD.

2. Methods

2.1. Participants

Participants were 87 women with a diagnosis of rape-related PTSD currently enrolled as a student at one of four universities/community colleges. Participants were recruited via posted advertisements on all four campuses (e.g., fliers, campus bus advertisements, advertisements in campus newspapers), postings on university psychology department participant management websites, as well as via social media (e.g., a study Facebook page, postings in student Facebook groups). Recruitment materials and the informed consent emphasized that the study was designed to evaluate the efficacy of online programs for women distressed about an unwanted sexual experience. All materials and study procedures were approved by the institutional review boards at the four participating universities/community colleges.

Diagnostic status and study eligibility was determined via a telephone interview conducted by study staff (either an advanced clinical psychology doctoral student or a postdoctoral fellow). Items from the Sexual Experiences Survey-Revised (SES-R) were administered to determine that participants had experienced a completed rape since the age of 14 (Koss et al., 2007). PTSD diagnosis was determined using the PTSD Symptom Scale Interview (PSS-I; Foa, Riggs, Dancu, & Rothbaum, 1993). Participants were instructed to respond to the items on the PSS-I in reference to their experience of completed rape, or their self-assessed worst experience of completed rape if they had experienced multiple rapes. Information about the characteristics of participants' rape experience (or worst rape experience) was assessed using an extant questionnaire (Littleton, Axsom, Breitkopf, & Berenson, 2006).

Exclusion criteria included currently receiving psychotherapy, lack of stability on psychotropic medication (individual has not been on current medication/dosage for at least three months), active suicidality as determined by interview utilizing the Scale for Suicidal Ideation (Beck, Kovacs, & Weissman, 1979), or meeting DSM-IV criteria for current substance dependence as assessed with the substance use disorder module of the SCID-IV (First, Spitzer, Gibbon, & Williams, 2002). In addition, all participants had to have regular access to a computer and a telephone number at which they could reliably be reached.

In total, 150 women were screened for eligibility via telephone. Of these, 87 women completed the screening and were determined to be eligible to participate. The most common reasons for ineligibility were reporting insufficient symptoms to meet diagnostic criteria for PTSD (31.3%, n = 20), currently receiving psychotherapy (26.6%, n = 17), or the individual had either experienced a completed rape that was a continuation of childhood sexual abuse committed by an authority figure/caregiver/relative or had not experienced a completed rape (15.6%, n = 10). Less frequent reasons for exclusion were current substance dependence (6.3%, n = 4),